Quarterly Provider Training

NEVADA MEDICAID AND NEVADA CHECK UP

Quarterly Training for Medicaid Providers
Updated July 2014

Agenda

- Nevada Medicaid and Nevada Check Up Recipients
- Nevada Medicaid and Nevada Check Up Providers
- Paid Claims
- Claim Review
- ICD-10 Delayed
- Ordering, Prescribing and Referring Providers (OPR)
- Provider Web Portal
- Claim Appeal Updates
- Web Announcements
- Questions?
- Contact Us

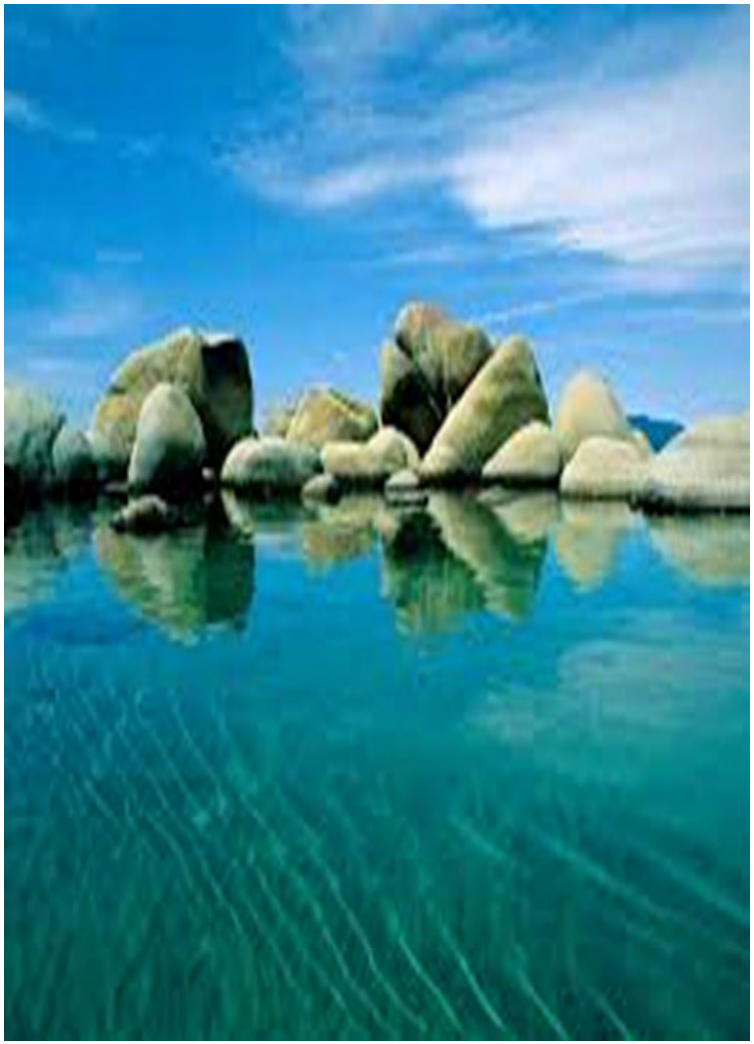
Nevada Medicaid and Nevada Check Up Recipients

Recipients Enrolled in Nevada Medicaid and Nevada Check Up

For the month of June 2014, recipients enrolled totaled:

Managed Care Enrollment

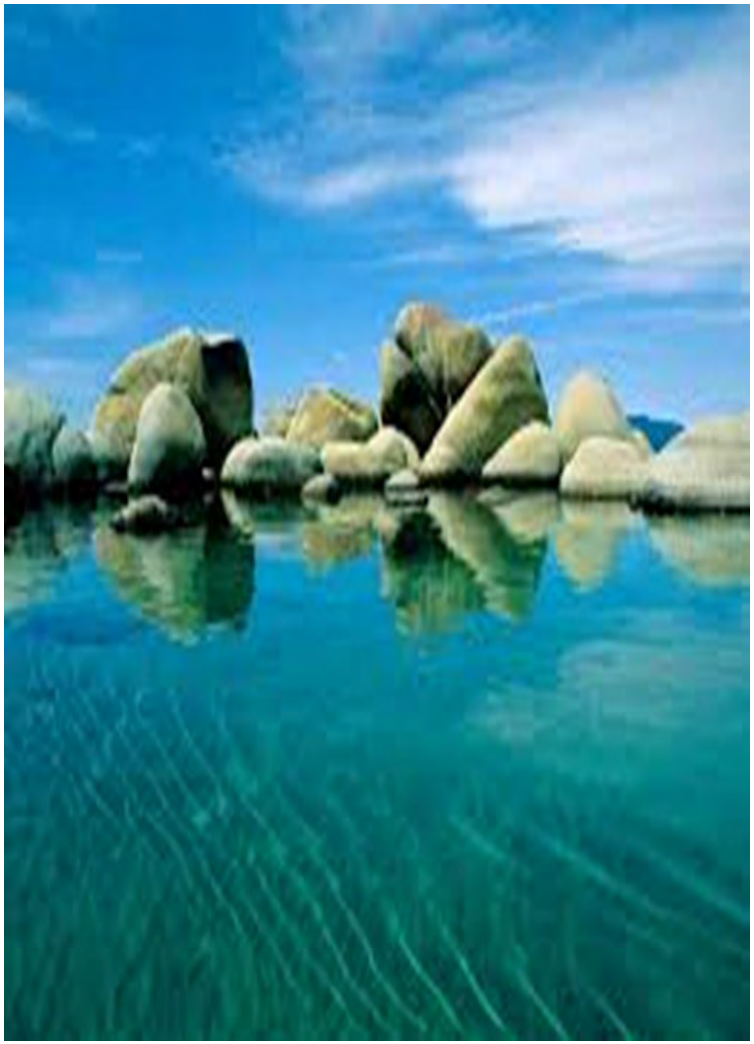
For the month of June 2014, recipients enrolled in Managed Care totaled:



Nevada Medicaid and Nevada Check Up Providers

Providers Enrolled in Nevada Medicaid and Nevada Check Up

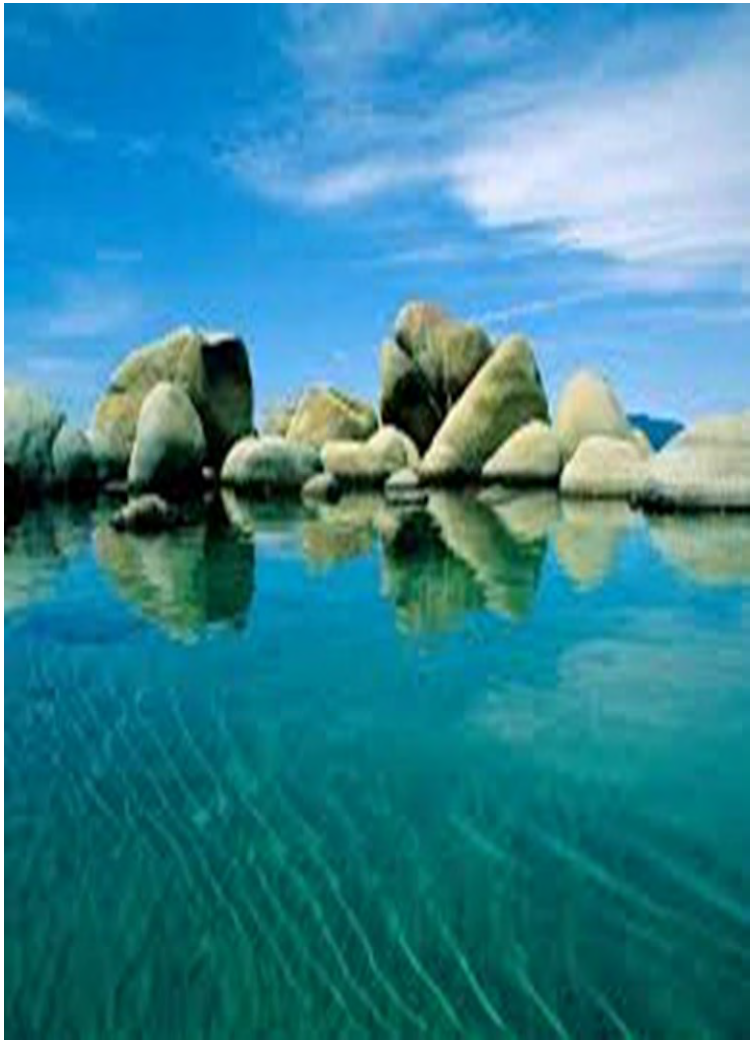
As of May 31, 2014 the total number of provider enrolled in Nevada Medicaid and Nevada Check Up was:



Paid Claims

Paid Claims

January 1, 2014 through May 31, 2104, Nevada Medicaid and Nevada Check Up paid out to providers in claims:



Claim Review

Top Claim Denial Reasons

- 0450 – Non Emergency Services not Authorized for Non-Citizens
- 0308 – Timely Filing
- 0155 - Procedure Requires Authorization

Top Claim Return Reasons on the CMS-1500 Claim Form (Version 02-12)

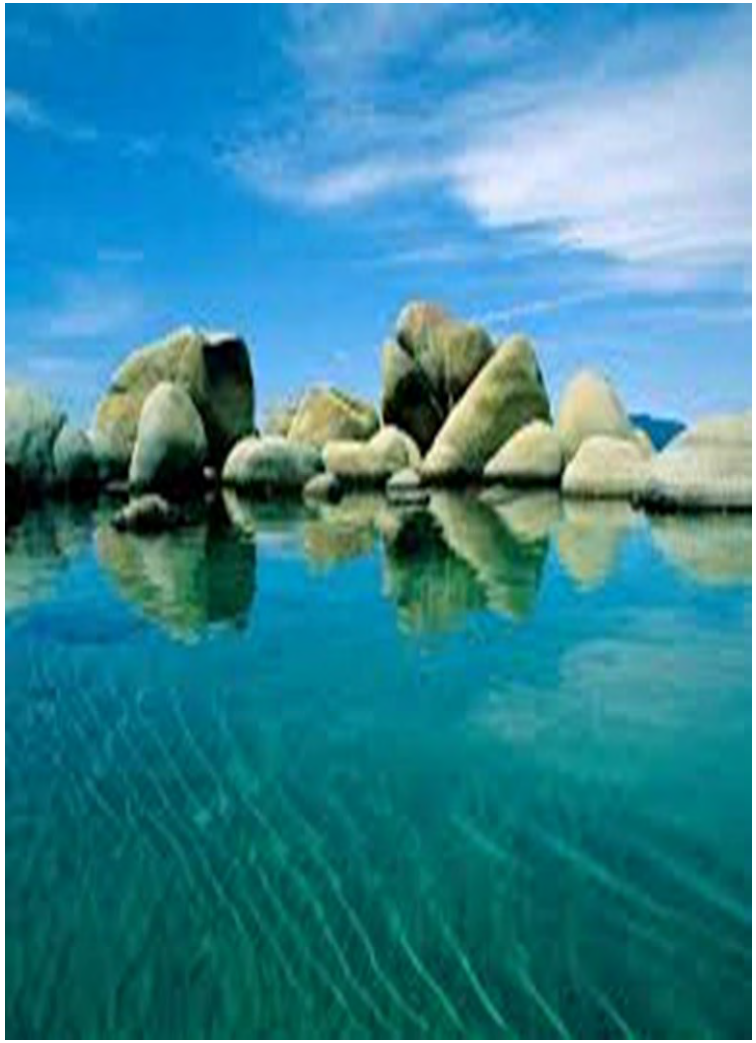
- Numeric diagnosis pointer reported in field 24E
- Balance due not included in field 30

Top Claim Return Reasons on the ADA Claim Form (Version 2012)

- Incorrect ADA claim form version submitted
- ICD-9 code(s) not reported in field 34a
- Missing diagnosis pointer in field 29a

Top Claim Return Reasons on the UB-04 Claim Form

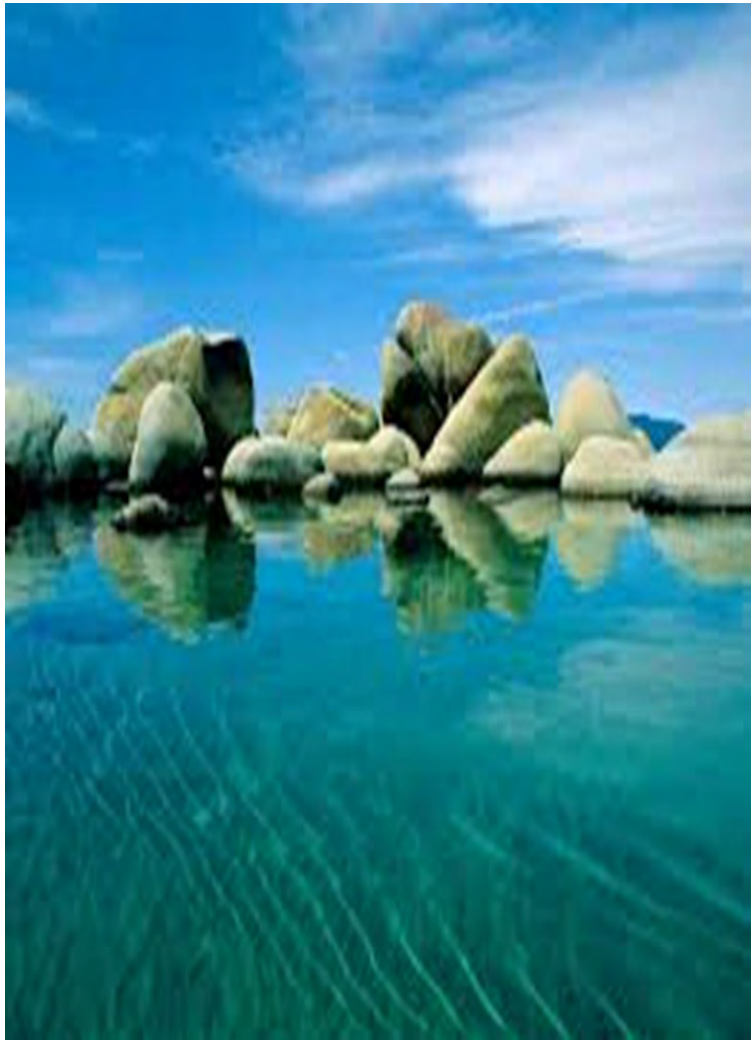
- Information on claim form is not legible
- Field 55 not completed



ICD-10 Delay

ICD-10 Delayed

- On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.



Ordering, Prescribing and Referring Providers (OPR)

Who Is an OPR Provider?

An OPR provider is a practitioner who:

- May occasionally see an individual who is a Medicaid recipient who needs additional services or supplies that will be covered by the Medicaid program.
- Does not want to be enrolled as another Medicaid provider type.
- Does not plan to submit claims for payment of services rendered

Why are OPR Providers Required to Enroll in Nevada Medicaid?

- With the implementation of the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) requires all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (42 CFR §455.410 Enrollment and Screening of Providers).

Why Are OPR Providers Required to Enroll in Nevada Medicaid?

- Traditionally, most providers have enrolled in the Nevada Medicaid program to furnish covered services to Medicaid recipients and to submit claims for such services. However, the Affordable Care Act (ACA) now requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid.

What if an OPR Provider Does Not Enroll as Required?

- It is important for OPR providers to understand the implications of failing to enroll in Medicaid. If you are an OPR provider, the physicians, other practitioners and facilities who actually render services to Medicaid recipients based on your order, prescription or referral, will not be paid for such items or services unless you enroll in Medicaid and your NPI is included on the claim submitted to Medicaid by the rendering provider (42 CFR 455.440).

What is the OPR Implementation Date?

July 18, 2014
Announcement 774

Ordering, Prescribing and Referring Provider Enrollment Requirement to be Implemented August 18, 2014

Effective August 18, 2014, the Division of Health Care Financing and Policy is implementing the requirement for Ordering, Prescribing and Referring (OPR) providers to be enrolled in Nevada Medicaid.

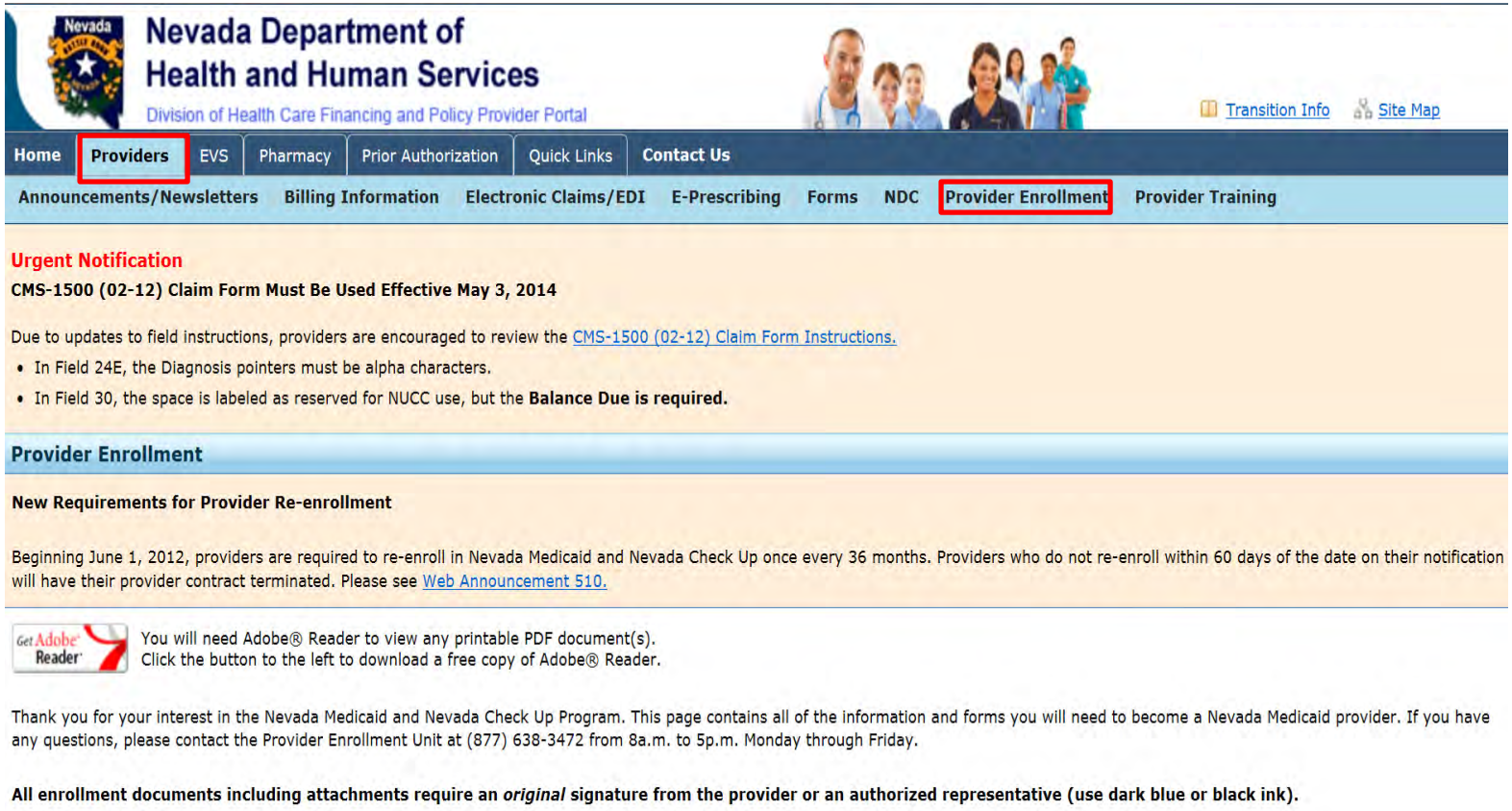
Effective with claims received by HP Enterprise Services (HPES) on or after October 15, 2014, the National Provider Identifier (NPI) of the Ordering, Prescribing or Referring (OPR) provider must be included on all Nevada Medicaid/Nevada Check Up claims **or those claims will be denied**.

In order for Medicaid to reimburse for services or medical supplies that require a provider's order, prescription or referral, the *Affordable Care Act* (*42 CFR Parts 405, 447, 455, 457* and *498*) requires that the ordering, prescribing or referring provider be enrolled in Medicaid. Providers may enroll by submitting a Provider Enrollment Application for Ordering, Prescribing and Referring Providers, which is posted on the Provider Enrollment webpage at www.medicaid.nv.gov.

Again, if the NPI of the ordering, prescribing or referring provider noted on the claim is not enrolled in the Nevada Medicaid program, for claims processed on or after October 15, 2014, the claim will not be paid.

Please note: The NPI on the OPR Enrollment Application must be for an individual physician or non-physician practitioner (not an organizational NPI).

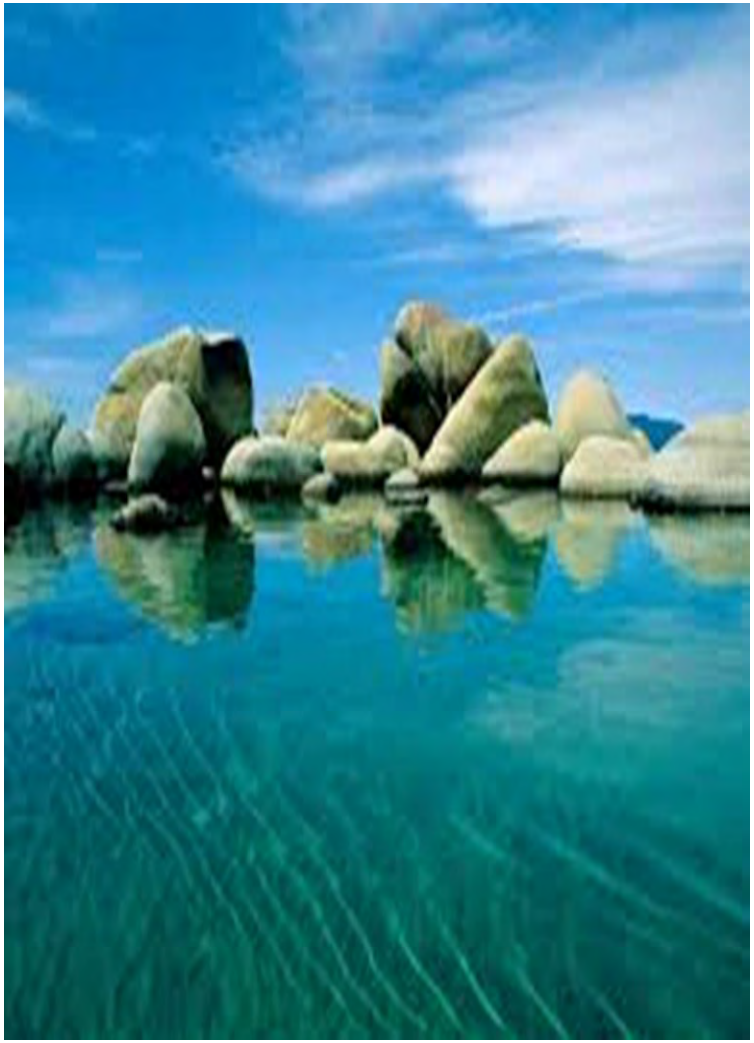
Where Can Additional Information Concerning OPR Be Found?



Where Can Additional Information Concerning OPR Be Found?

Ordering, Prescribing and Referring Provider Enrollment Frequently Asked Questions (FAQs) are posted on the Provider Enrollment webpage under Ordering, Prescribing and Referring Provider Enrollment Documents:

http://www.medicaid.nv.gov/providers/enroll.aspx



Provider Web Portal

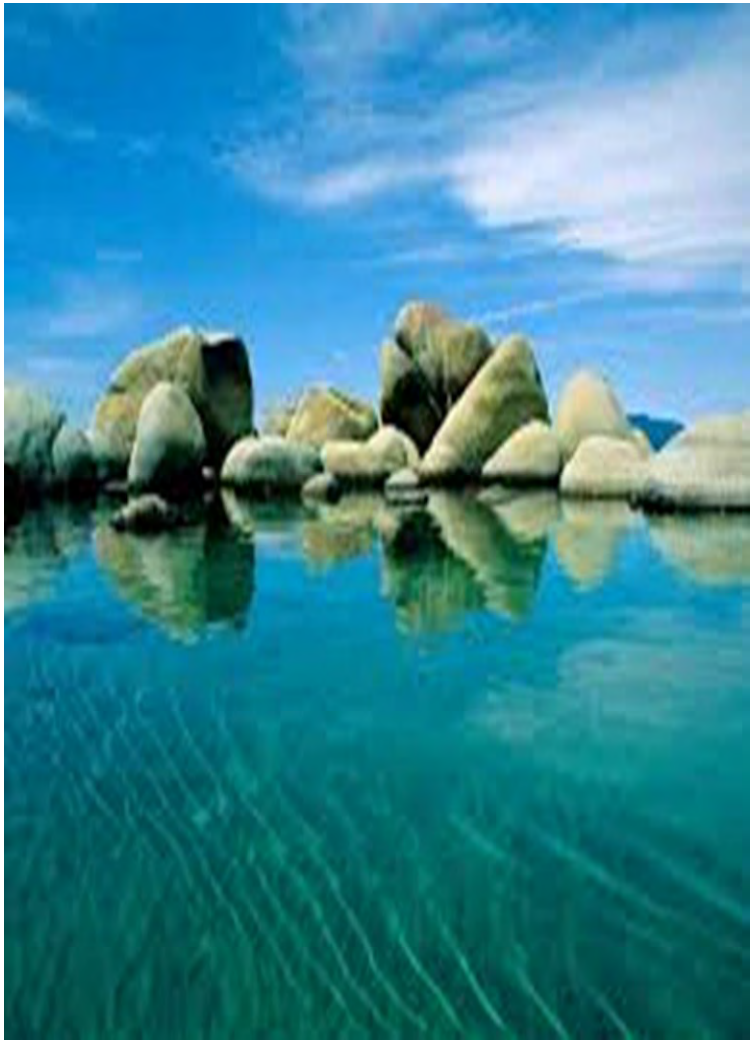
What Can You Do in the Provider Web Portal?

- Inquire on the status of claims and payments
- Inquire on a recipient's eligibility
- Process prior authorization requests
- Access remittance advices

Who Can You Contact with Questions about the Provider Web Portal?

- Provider Web Portal Helpdesk
  (877) 638.3472 and select the appropriate option for Provider Web Portal assistance

- You can also contact your Provider Services Field Representative directly

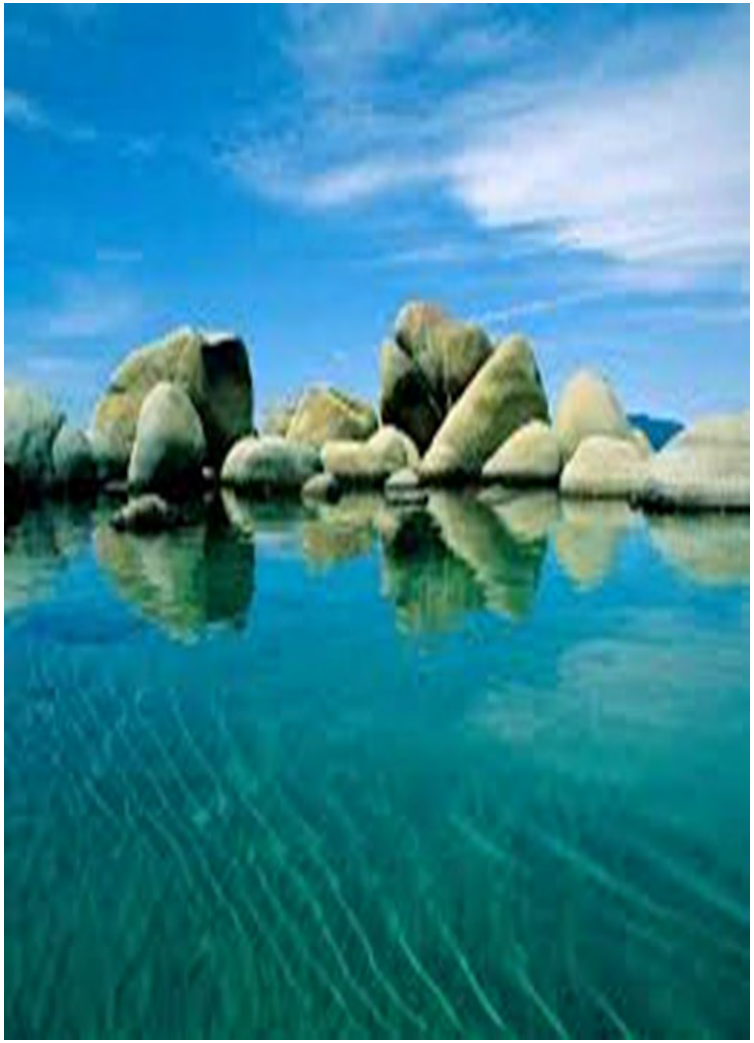


Claim Appeal Updates

Claim Appeals

Claim Appeals must include the following documents:

- A letter addressing the specific reason for the appeal, which includes the provider name and NPI/API, the ICN of the claim and the name and phone number of the person to be contacted regarding the appeal (an FA-90 is also acceptable)
- Documentation to thoroughly support the appeal request
- An original signed paper claim that may be used for the processing should the appeal be approved



Web Announcements

Web Announcement 721

April 17, 2014

Announcement 721

Report Contact and Address Changes on Form FA-33

Providers are required to ensure that their current contact information and physical address are on file with HP Enterprise Services (HPES). Current information assists the HPES Provider Services Field Representatives in contacting the correct person on your staff when needed.

Changes to enrollment information after you enroll (except changes in business ownership) must be updated via form FA-33 within five (5) business days of the change. Business ownership changes must be reported within five (5) business days by resubmitting a complete, new set of enrollment documents and a copy of the purchase agreement.

FA-33 – Provider Information Change Form – is available on the Provider Enrollment webpage and the Provider Forms webpage at www.medicaid.nv.gov. The form can be faxed to (775) 335-8593 or mailed to HP Enterprise Services, Provider Enrollment, P.O. Box 30042, Reno NV 89520-3042.

Web Announcement 722

April 18, 2014

Announcement 722

Frequently Asked Questions (FAQs) Regarding Enrollment Requirement for Ordering, Prescribing and Referring Providers

A Frequently Asked Questions (FAQ) reference has been created to assist providers with the details regarding the implementation of the requirement for ordering, prescribing and referring providers to enroll in Nevada Medicaid.

The FAQs are available at the following link Ordering, Prescribing and Referring Provider Enrollment Frequently Asked Questions and are also posted on the Provider Enrollment and Pharmacy Announcements webpages at www.medicaid.nv.gov.

Web Announcement 728

April 23, 2014

Announcement 728

Use Provider Web Portal System to Request a Review for an Initial or Continued Services Prior Authorization

Please remember to use the Provider Web Portal online prior authorization system only to request an initial prior authorization (PA) or a continued service PA. If non-clinical or administrative changes need to be made to a previously submitted authorization, please use the appropriate data correction form. The forms can be found online at www.medicaid.nv.gov on the Provider Forms webpage in the Prior Authorization Forms table. Some examples of non-clinical or administrative data changes are revising the start or stop dates of a PA request or correcting the National Provider Identifier (NPI) of the provider. Please verify that another PA has not been entered to avoid duplicating a request.

For Residential Treatment Centers (RTCs): The begin date for an RTC stay will be adjusted as per the data correction and the end date and the number of units will remain as originally authorized.

Web Announcement 729

April 23, 2014
Announcement 729

URGENT REMINDER: Dual-Use Periods Are Ending for ADA and CMS-1500 Claim Forms; New Forms Must Be Used

2012 ADA Claim Form Must Be Used Effective May 1, 2014

Effective with claims received at HP Enterprise Services (HPES) on or after May 1, 2014, the new 2012 American Dental Association (ADA) claim form must be used. The dual-use period of the 2006 version and the 2012 version ends on April 30, 2014. Effective May 1, 2014, claims submitted with the 2006 ADA claim form will be returned to providers.

- **Please note:** For dates of service on or after May 1, 2014, claims on the 2012 ADA form will deny if **valid diagnosis codes and diagnosis pointers** (Fields 29a and 34a) and **place of treatment codes** (Field 38) are not included on the claim. Please review the 2012 ADA Claim Form Instructions.
- Electronic billers: Please refer to the Transaction 837D – Dental Health Care Claim and Encounter Companion Guide for billing instructions. The Companion Guides are available on the Electronic Claims/EDI webpage.

CMS-1500 (02-12) Claim Form Must Be Used Effective May 3, 2014

Effective with claims received at HP Enterprise Services (HPES) on or after May 3, 2014, the new CMS-1500 (02-12) claim form must be used. The dual-use period of version 02-12 and version 08/05 ends on May 2, 2014. Effective May 3, 2014, claims submitted with the CMS-1500 (version 08/05) claim form will be returned to providers.

Due to updates to field instructions, providers are encouraged to review the CMS-1500 (02-12) Claim Form Instructions. For example:

- In Field 21, enter up to twelve (12) ICD-9 codes in the spaces indicated A through L. Please enter the codes **across each line**, not down.
- In Field 24E, the Diagnosis pointers must be alpha characters. They are no longer numeric values. If you enter multiple codes in Field 21, then in Field 24E use a dash between the first and last letters, i.e., A-D, instead of ABCD. Please note: This is a claim form field in which dashes are acceptable.
- In Field 30, the space is labeled as reserved for NUCC use, but the **Balance Due is required**. If Medicaid is primary coverage, enter the amount shown in Field 28. If the recipient has Third Party Liability (TPL) (including Medicare), enter the recipient's legal obligation to pay. Do not include write-off, contractual adjustment or behavioral health reduction amounts.
- Electronic billers: Please refer to the Transaction 837P – Professional Health Care Claim and Encounter Companion Guide for billing instructions. The Companion Guides are available on the Electronic Claims/EDI webpage.

Web Announcement 731

May 8, 2014

Announcement 731

Notice of Decision (NOD) Letters Show 30-Day Detail

Formatting of Notice of Decision (NOD) letters regarding a prior authorization (PA) request have been changed. Letters will now only contain details of decisions made in the last 30 days under that specific PA number. NOD letters previously included all decisions made under that specific PA number.

Web Announcement 732

May 12, 2014
Announcement 732

Changes to Recipient Search Criteria in the Provider Web Portal Online System

Eligibility:

- Eligibility searches using the Social Security Number (SSN) will now accept SSNs that begin with 7, 8 and 9.

Member Focus Viewing Searches:

The **Search** tab allows you to search for recipients and select a recipient to view. When searching for recipients using name information, you must enter the complete first and last name information. Partial name searches are not supported and will generate a "not found" search response.

- "First Name" searches are now limited to 20 characters.
- "Last Name" searches are now limited to 25 characters.

The **Search** feature has been enhanced to return additional recipients that may not currently be active in the system. Search results obtained in Member Focus Search will now match the results obtained when searching using Eligibility.

Web Announcement 733

May 12, 2014

Announcement 733

Reimbursement Methodology for ESRD Providers Changes to Bundled Prospective Payment Rate

Per the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Medicaid has changed the process for its reimbursement to End Stage Renal Disease (ESRD) Facilities (provider type 45) from a composite rate to a bundled prospective payment system (PPS). The PPS will include all resources used in providing outpatient dialysis treatment, including biologicals and drugs.

Effective with claims with dates of service on or after May 12, 2014, provider type 45 must bill services using CPT code 90999 (Unlisted dialysis procedure, inpatient or outpatient), which will include all treatment associated with ESRD services. Any drugs administered not included in the PPS must be billed by NDC.

For a list of drugs included in the PPS refer to the CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 2134. For more information regarding the new reimbursement system, please refer to Section 153(b) of the MIPPA and the Code of Federal Regulations Title 42 Part 413.171.

Web Announcement 734

May 16, 2014
Announcement 734

PERM Cycle 3 Provider Education Webinar/Conference Calls

The Centers for Medicare & Medicaid Services (CMS) will host four Payment Error Rate Measurement (PERM) provider education webinar/conference calls during Cycle 3 (2014). The purpose is to provide opportunities for the providers of the Medicaid and Children's Health Insurance Program (CHIP) communities to enhance their understanding of specific provider responsibilities during the PERM.

The PERM program is designed to measure improper payments in the Medicaid and CHIP programs, as required by the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA, and the Improper Payments Elimination and Recovery Improvement Act of 2012 or IPERIA).

Webinar/conference call participants will learn from presentations that feature:

- The PERM process and provider responsibilities during a PERM review
- Recent trends, frequent mistakes and best practices
- The Electronic Submission of Medical Documentation "esMD" program

The presentations will be repeated for each session. Providers will have the opportunity to ask questions live through the conference lines, via the webinar, and through the dedicated PERM Provider email address at PERMProviders@cms.hhs.gov.

Presentation materials and participant call-in information will be posted as downloads on the "Providers" tab of the PERM website at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Providers.html

The webinars are being presented on the Adobe Connect Pro platform. To test your connection in advance, launch: https://webinar.cms.hhs.gov/common/help/en/support/meeting_test.htm

Tuesday, June 10, 2014 noon-1 p.m. Pacific Time

The two-step audio/webinar process is:

1. **Audio:** Login to https://cms.webex.com/cms/j.php?J=992454311 The call-in#/meeting ID/access code will display on your screen (keep this open) when you dial in.
2. **Webinar:** In a separate window, login to https://webinar.cms.hhs.gov/perm2014cycle3web/ to access the webinar.

Thursday, June 26, 2014 noon-1 p.m. Pacific Time

The two-step audio/webinar process is:

1. **Audio:** Login to https://cms.webex.com/cms/j.php?J=998353879 The call-in#/meeting ID/access code will display on your screen (keep this open) when you dial in.
2. **Webinar:** In a separate window, login to https://webinar.cms.hhs.gov/perm2014cycle3web/ to access the webinar.

Wednesday, July 16, 2014 noon-1 p.m. Pacific Time

The two-step audio/webinar process is:

1. **Audio:** Login to https://cms.webex.com/cms/j.php?J=997166126 The call-in#/meeting ID/access code will display on your screen (keep this open) when you dial in.
2. **Webinar:** In a separate window, login to https://webinar.cms.hhs.gov/perm2014cycle3web/ to access the webinar.

Wednesday, July 30, 2014 noon-1 p.m. Pacific Time

The two-step audio/webinar process is:

1. **Audio:** Login to https://cms.webex.com/cms/j.php?J=991531095 The call-in#/meeting ID/access code will display on your screen (keep this open) when you dial in.
2. **Webinar:** In a separate window, login to https://webinar.cms.hhs.gov/perm2014cycle3web/ to access the webinar.

CMS encourages all participants to submit questions not addressed in the session to the dedicated PERM Provider email address at PERMProviders@cms.hhs.gov or you may also contact **your** State PERM representatives with any questions and for information about education and training.

Please check the CMS Website and PERM Provider's page regularly for helpful education materials, FAQs and updates at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Providers.html.

Web Announcement 736

May 28, 2014

Announcement 736

Reminders for Providers Who Submit PASRR and LOC Requests

Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.

A Level of Care (LOC) assessment is required for all Medicaid-eligible individuals seeking nursing facility placement to determine if the individual meets nursing facility level of care criteria.

Both PASRR and LOC screenings can be submitted online via the HP Enterprise Services (HPES) PASRR system. In order to access the PASRR system, providers must first register for the Electronic Verification System (EVS). Once EVS registration has been completed, delegates may sign in to the PASRR application from the EVS homepage and can then request activation of roles for the PASRR system.

To register for EVS, please go to www.medicaid.nv.gov and select the "EVS" tab. Instructions for registering for EVS are located in the User Manual under the "EVS" tab. You may also call customer service at (877) 638-3472 for assistance with EVS registration.

Once you are registered for EVS and have successfully logged in to the PASRR system, you can call the HPES PASRR department for assistance at (775) 335-8556.

Web Announcement 737

May 29, 2014
Announcement 737

Reminder: Valid ICD-9 and/or Principal Diagnosis Codes Required on CMS-1500, UB and ADA Claim Forms

Valid ICD-9 diagnosis codes and/or principal diagnosis codes are required on all paper and electronic CMS-1500, UB and ADA claims submitted by any provider type. Please refer to the claim form instructions posted on the Provider Billing Information webpage at www.medicaid.nv.gov.

Please note: The CMS-1500 and ADA claim forms also require the appropriate diagnosis pointers.

Web Announcement 739

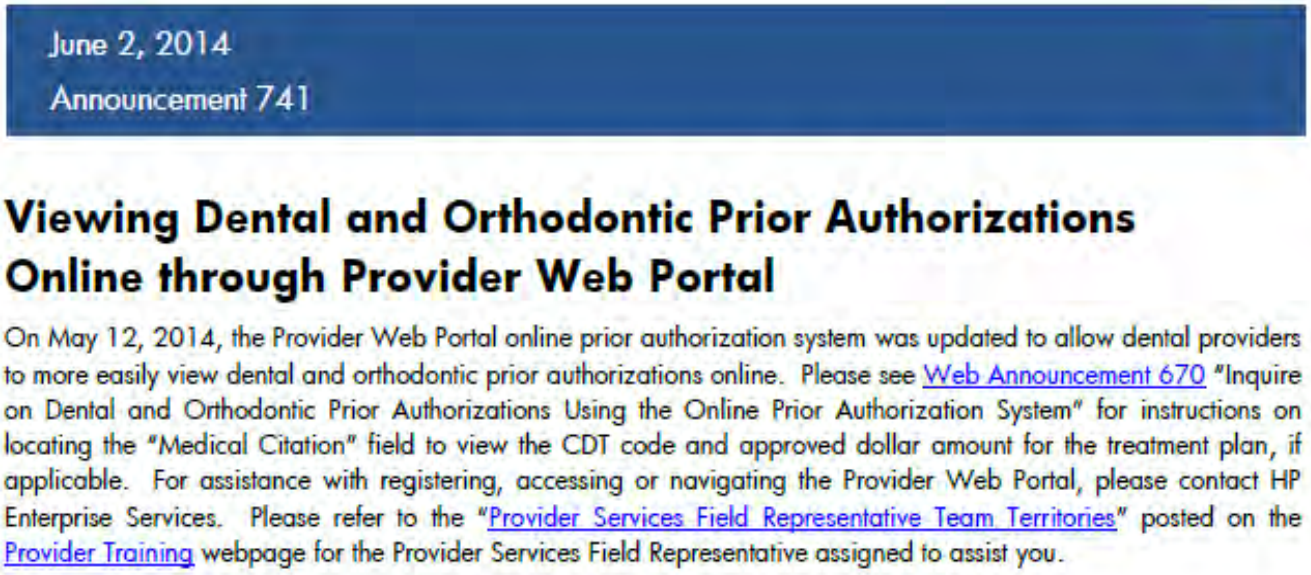
May 30, 2014

Announcement 739

Cesarean Section Diagnosis Code List Updated

The list of Cesarean Section Diagnosis Codes Accepted by Nevada Medicaid has been updated. The list is available by selecting "Procedure and Diagnosis Reference Lists" from the "Prior Authorization" tab at www.medicaid.nv.gov.

Web Announcement 741



June 2, 2014

Announcement 741

Viewing Dental and Orthodontic Prior Authorizations Online through Provider Web Portal

On May 12, 2014, the Provider Web Portal online prior authorization system was updated to allow dental providers to more easily view dental and orthodontic prior authorizations online. Please see Web Announcement 670 "Inquire on Dental and Orthodontic Prior Authorizations Using the Online Prior Authorization System" for instructions on locating the "Medical Citation" field to view the CDT code and approved dollar amount for the treatment plan, if applicable. For assistance with registering, accessing or navigating the Provider Web Portal, please contact HP Enterprise Services. Please refer to the "Provider Services Field Representative Team Territories" posted on the Provider Training webpage for the Provider Services Field Representative assigned to assist you.

Web Announcement 742

June 3, 2014

Announcement 742

Launch Date for Nevada's Health Care Guidance Program Scheduled for June 1, 2014

The Nevada Division of Health Care Financing and Policy (DHCFP) is launching a new Care Management Organization (CMO), known as the Health Care Guidance Program, on June 1, 2014. This program will provide care management services to eligible Medicaid fee-for-service recipients.

The CMO Team at the DHCFP shared the vision and objectives of the Health Guidance Program to stakeholders and medical providers across the state.

During the DHCFP's outreach, the DHCFP became abundantly aware of how such a program could positively impact Medicaid's sickest fee-for-service recipients. The program is designed to help improve health outcomes for individuals who live with chronic health conditions by offering additional support to enrollees and providers. Coordinating transitional care, follow-up appointments, support services, preventive health and use of health information technology are all components of this program.

The DHCFP contracted with McKesson to manage the CMO. In early June, Nevada Medicaid providers will receive a handbook with information about the program details. Providers with questions regarding this program may call the Health Care Guidance Program at (855) 606-7875, option 2.

Web Announcement 746

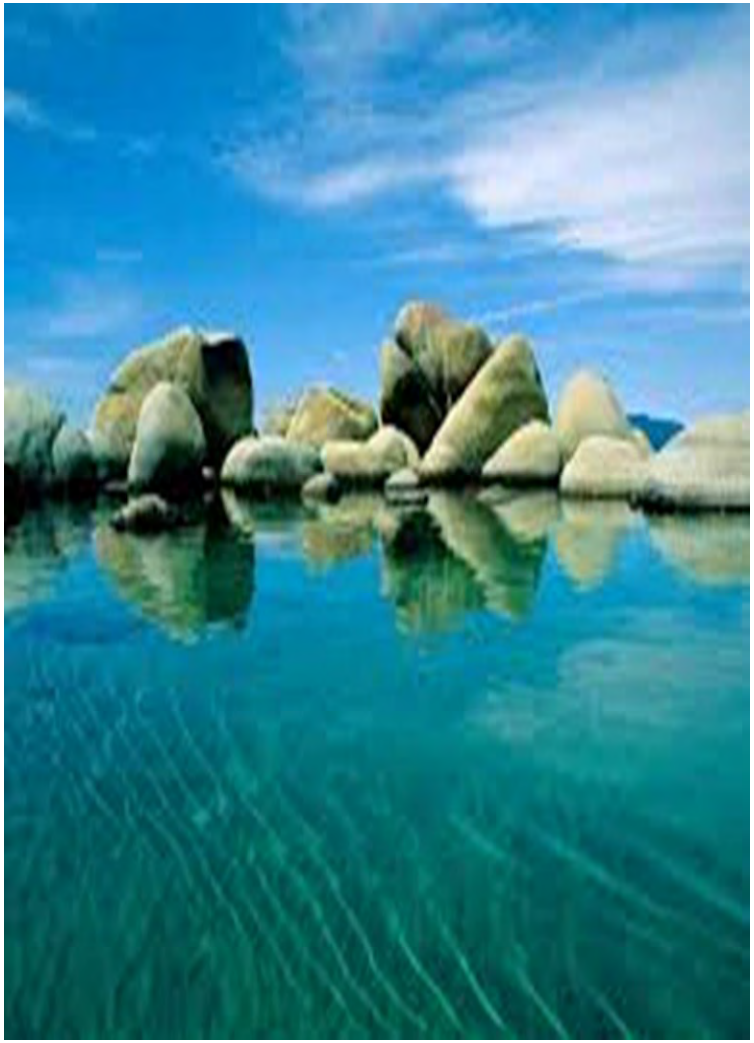
June 6, 2014

Announcement 746

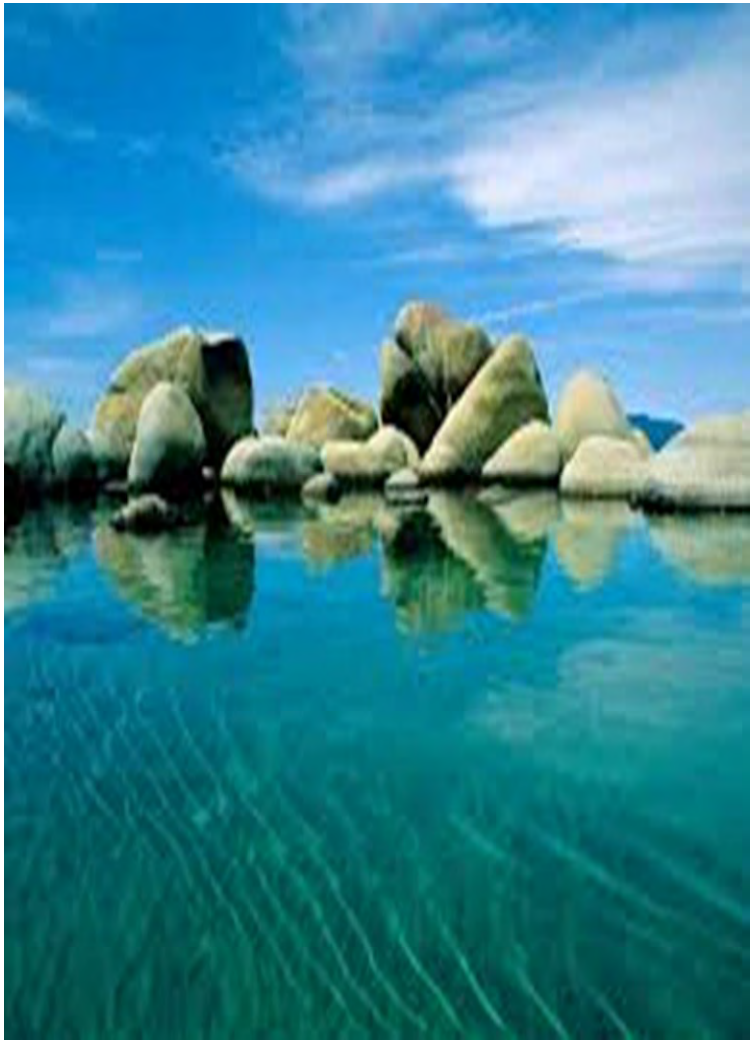
Clinical Claim Editor Updated with Current NCCI Edits

The clinical claim editor in the Medicaid Management Information System (MMIS) has been updated with the current Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) files. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported. Claims received by HP Enterprise Services (HPES) on or after June 2, 2014, are being adjudicated with the most current NCCI edit files.

A previous clinical claim editor update, which installed the 2013 CMS Medicaid NCCI files and the KB 51 upgrade, began adjudicating claims on September 16, 2013.



Questions?



Contact Us

Contact Information

The Nevada Medicaid Provider Services Field Representative Team is available to assist you. To find your representative's contact information:

- www.medicaid.nv.gov
- Select the "Provider" tab
- Select the "Provider Training" option
- Scroll to the bottom of the page
- Select the "Provider Services Field Representative Team Territories" link
- Locate the corresponding provider type or zip code for your servicing provider